



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FRWY, SUITE 2200
HOUSTON TX 77027

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-08-0057-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the hospital's position that the hospitalization was an emergency and trauma as defined pursuant to the Acute Care Hospital Fee guideline. Liberty Mutual issued an underpayment of \$5,956.32 as a fair and reasonable reimbursement for trauma admits." "It is the hospital's position that the patient required emergency medical treatment to resolve her complicated medical condition. Because there is no certainty or predictability as to what a patient's needs will be in any given emergency admit, the cost of providing necessary care and treatment cannot be predicted with any degree of certainty."

Amount in Dispute: \$27,093.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2006 through September 15, 2006	Inpatient Services	\$27,093.93	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that

when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.

3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on August 29, 2007.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology .
 - W1-Workers Compensation state fee schedule adjustment.
 - 97-Payment is included in the allowance for another service/procedure.
 - Z585-The charge for this procedure exceeds fair and reasonable.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
 - X094-Charges included in the facility fee.
 - Z711-the charge for this procedure exceeds the customary charges by other providers for this service.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 813.32. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
3. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "It is the hospital's position that the hospitalization was an emergency and trauma as defined pursuant to the Acute Care Hospital Fee guideline. Liberty Mutual issued an underpayment of \$5,956.32 as a fair and reasonable reimbursement for trauma admits." "It is the hospital's position that the patient required emergency medical treatment to resolve her complicated medical condition. Because there is no certainty or predictability as to what a patient's needs will be in any given emergency admit, the cost of providing necessary care and treatment cannot be predicted with any degree of certainty"
 - The requestor does not discuss or explain how additional payment of \$27,093.93 would result in a fair and reasonable reimbursement.
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.

- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 TexReg 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	9/13/2011
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	9/13/2011
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.